Standard Form 2809
Rev. August 1992

FEHB
Federal Employees
Health Benefits Program

Form Approved:
OMB No. 3206-0160

Health Benefits Registration Form

Uses for Standard Form (SF) 2809

Use this form to:

* Enroll in the FEHB Program; or
* Elect not to enroll in the FEHB Program (employees only); or
* Change your FEHB enrollment from Self Only to Self and Family and/or from your present plan or option to another plan or option because of an event described in the Table on page 6; or
* Change you FEHB enrollment from Self and Family to Self Only; or
* Cancel your FEHB enrollment.

Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a.
2. Annuitants (other than CSRS/FERS annuitants) eligible to enroll in or currently enrolled in the FEHB Program, including individuals receiving monthly compensation from the Office of Workers' Compensation Programs.

Note: CSRS/FERS annuitants -- **Do not use this form.** To obtain the appropriate form, write to:

Office of Personnel Management
Insurance Services Branch
P.O. Box 14172
Washington, D.C. 20044

3. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
4. Individuals eligible for temporary continuation of coverage under the FEHB Program, including:
   * Former employees (who separated from service);
   * Children who lose FEHB coverage; and
   * Former spouses who are not eligible for FEHB under Item 3 above.

Note: *Former spouses and children of CSRS/FERS annuitants --* ***Do not use this form.*** *To obtain the appropriate form, write to address shown in Item 2 above.*

Instructions for Completing SF 2809

Type or Print Firmly

PART A. You must complete this part.

Item 1. Give your last name, first name and middle initial.

Item 2. Enter your Social Security Number. (See Privacy Act Statement on Page 5.)

Item 3. Give your date of birth, using numbers to show the month, day and year.

Item 4. Enter your permanent home mailing address.

Item 5. Place an "X" in the appropriate box.

Item 6. Place an "X" in the box that signifies your current marital status (if you are separated but not divorced, you are still married).

Item 7. Give your telephone number where you can be reached during normal business hours. Be sure to include the area code.

PART B. Complete this part to enroll or change your enrollment in the FEHB Program. (If you are changing your enrollment, also complete PART C.)

Item 1. Enter the plan name and appropriate enrollment code from the front cover of the brochure of the plan you want to enroll in or change to. (The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.) If you are just changing from one option to another and/or from Self Only to Self and Family or from Self and Family to Self Only, enter the name of your present plan and the new enrollment code.

If the plan you want is a prepaid plan (CMP/HMO), be sure you live in the plan's enrollment area. If it is an employee organization plan, be sure you are eligible to enroll in the plan; you must be or become a member of the plan's sponsoring organization.

Your signature in Part F authorizes deductions from your salary, annuity or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

Items *2a through 2f.*

Complete these items only if your enrollment is for Self and Family. (If you need extra space for additional family members, list them on a separate sheet and attach.)

Item 2a. Indicate the first name and middle initial of each covered family member.

Item 2b. Provide the ZIP code if it is different from the enrollee's ZIP code in Part A, item 4.

Item 2c. Give your dependent's date of birth, using numbers to show the month, day and year. (e.g., 06/30/91)

Item 2d. Indicate *M* for male or *F* for female.

Item 2e. Provide the code which indicates the relationship of the eligible family member to you.

1. Spouse
2. Unmarried dependent child under age 22 (including an adopted child)
3. Step child, foster child or recognized child
4. Unmarried disabled child over age 22 incapable of self support.

Item 2f. Please provide Social Security Numbers for your dependents if available. If not available, leave blank; benefits will not be withheld. (See Privacy Act Statement on page 5.)

Family Members Eligible for Coverage

* Unless you are a former spouse, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 22. Eligible children include your legitimate or adopted children; and recognized children born out of wedlock, stepchildren or foster children, if they live with you in a regular parent-child relationship. A recognized child born out of wedlock also may be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

  Other relatives, *e.g.*, your parents are **not** eligible for coverage even though they live with you and are dependent upon you.

* If you are a former spouse, family members eligible for coverage under your Self and Family enrollment are the unmarried dependent natural or adopted children under age 22 of both you and your former spouse.

* Children whose marriage ends before they reach age 22 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 22.

* In some cases, an unmarried disabled child who is 22 years old or older is eligible for coverage under your Self and Family enrollment if you have adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday and renders the child incapable of self-support.

Note: *Your employing office (see Note under General Information on page 3) can give you additional details about family member eligibility, including the documentation required for coverage of a disabled child age 22 or older.*

Item 3a. Place an "X" in the appropriate box if you completed item 1 of this part. If you answer "Yes," complete items 3a through 3b.

Item 3b. Indicate any additional insurance coverage for you or your dependents. Indicate what part(s) of Medicare coverage are held: Indicate "A", if you have Part A, Medicare Hospital Insurance and/or Indicate "B", if you have Part B, Medicare Supplementary Medical Insurance. Indicate "A and B" if you have both.

PART C. You must complete this part if you are changing your enrollment.

Item 1. Enter the name of the plan in which you are presently enrolled.

Item 2. Enter your present enrollment code.

Item 3. Enter the number of the event that permits your change from the Table on page 6. (Leave this item blank if you are changing from Self and Family to Self Only.)

Item 4. Using numbers, enter the date of the event that permits your change. For Open Season changes, enter the date on which the Open Season begins. (Leave this item blank if you are changing from Self and Family to Self Only.)

PART D. Place an "X" in the box provided only if you are an employee who does not wish to enroll in the FEHB Program. **(Be sure to read the information about electing not to enroll on page 4.)**

PART E. Place an "X" in the box provided if you wish to cancel your FEHB enrollment. Also enter your present enrollment code in the space provided. **(Be sure to read the information about cancelling your enrollment on page 4.)**

PART F. You must complete this part.

Item 1. Sign your name. Do not print.

Item 2. Enter the date you sign, using numbers to show the month, day and year.

Leave ***PART G and REMARKS*** section blank. They are for agency use only.

If You are Registering for Someone Else

If you are registering for an employee or an annuitant, under a written authorization from him or her to do so, sign your name in Part F and attach the written authorization.

If you are registering for a former spouse eligible for coverage under Spouse Equity or for an individual eligible for temporary continuation of coverage as his or her court-appointed guardian, sign your name in Part F and attach evidence of your court-appointed guardianship.

General Information

The following material about the FEHB Program will be furnished to you by, or may be obtained from, your employing office (see ***Note*** below):

FEHB plan brochures, which contain detailed information about plan benefits and the contractual description of coverage.

Employees

FEHB Program Information for Federal Civilian Employees and U.S. Postal Service Employees (SF 2809-A), which explains your rights and obligations under the program.

FEHB Enrollment Information Guide and Plan Comparison Chart, which contains enrollment, plan and rate information, as follows:

RI 70-1	Federal Employees (Non-Postal)
RI 70-2	Postal Employees
RI 70-7	Employees in Positions Outside the Continental U.S. (including Alaska, Hawaii, Guam and Puerto Rico)
RI 70-8	Temporary Employees Eligible for FEHB Under 5 U.S.C. 8906a.
RI 70-10	Visually Impaired Employees

Annuitants

FEHB Enrollment Information Guide and Plan Comparison Chart, which contains enrollment, plan and rate information for:

Annuitants in retirement systems other than CSRS/FERS (RI 70-4)

Individuals receiving compensation from the Office of Workers' Compensation Programs (RI 70-6)

Former Spouses (Spouse Equity)

FEHB Enrollment Information Guide and Plan Comparison Chart, which contains enrollment, plan and rate information for former spouses (RI 70-5)

Individuals Eligible for Temporary Continuation of Coverage

FEHB Enrollment Information Guide and Plan Comparison Chart, which contains enrollment, plan and rate information for former employees, children and former spouses eligible for temporary continuation of coverage (RI 70-5)

Note: *"Employing office" means the office of an agency or retirement system that is responsible for health benefits actions for an employee, an annuitant, a former spouse eligible for coverage under Spouse Equity or an individual eligible for temporary continuation of coverage.*

Dual Enrollment

Normally, you are not eligible to enroll if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to:

Protect the interests of children who otherwise would lose coverage as family members, or

Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for Self and Family coverage.

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Program. (Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment.)

Temporary Continuation of Coverage (TCC)

While the employing office notifies a former employee of his or her eligibility for temporary continuation of coverage, the employing office must be notified when a child or former spouse becomes eligible.

For the eligible child of an enrollee, the enrollee must notify the employing office within 60 days after the qualifying event occurs, e.g., child reaches age 22.

For the eligible former spouse of an enrollee, the enrollee or the former spouse must notify the employing office within 60 days after the former spouse's change in status, e.g., the date of the divorce or former spouse's remarriage before reaching age 55.

An individual eligible for temporary continuation of coverage who wants to continue FEHB coverage may choose any plan (for which he or she is eligible), option and type of enrollment. The time limits for a former employee, child or former spouse to file the SF 2809 with the employing office appear in Events No. 24, 25 and 26 in the Table on page 6.

Note: *If someone other than the enrollee notifies the employing office of the child's eligibility for temporary continuation of coverage within the specified time period, the child's opportunity to file the SF 2809 ends 60 days after the qualifying event. If someone other than the enrollee or the former spouse notifies the employing office of the former spouse's eligibility for continued coverage within the specified time period, the former spouse's opportunity to file the SF 2809 ends 60 days after the change in status.*

Effective Dates

Your employing office can give you the specific date on which your enrollment or enrollment change will take effect. Additional information about effective dates appears in the Table on page 6.

Note 1: *If you are changing your enrollment from Self and Family to Self Only so that your spouse can enroll for Self Only, you should coordinate the effective date of your spouse's enrollment with the effective date of your enrollment change to avoid a gap in your spouse's coverage.*

Note 2: *If you are cancelling your enrollment and intend to be covered under someone else's enrollment at the time you cancel, you should coordinate the effective date of your cancellation with the effective date of your new coverage to avoid a gap in your coverage.*

Cancellation of Enrollment

You may cancel your enrollment at any time. However, if you cancel, neither you nor any family member covered by your enrollment will be entitled to a 31-day extension of coverage for conversion to nongroup coverage. Moreover, family members who lose coverage because of your cancellation will not be eligible for temporary continuation of coverage. (Be sure to read the additional information below about cancelling your enrollment.)

Employees Who Elect Not to Enroll or Who Cancel Their Enrollment

To be eligible for an FEHB enrollment after you retire, you must retire:

Under the retirement system for Federal civilian employees, and

On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

The five years of service immediately before retirement (i.e., commencing date of annuity entitlement), or

If fewer than five years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 31 days after your first appointment (in your Federal career) to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

If you do not enroll at your first opportunity or if you cancel your enrollment, you may later enroll or reenroll only under the circumstances explained in the Table on page 6. Some employees delay their enrollment or reenrollment until time to qualify for FEHB coverage as a retiree; however, there is always the risk that they will have to retire earlier than expected (e.g., due to disability or involuntary separation) and not be able to meet the five-year requirement for continuing FEHB coverage into retirement. Please understand that when you elect not to enroll or cancel your enrollment **you are voluntarily accepting this risk**. An alternative would be to enroll in or change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

Note: *Temporary employees eligible for FEHB under 5 U.S.C. 8906a -- Your decision not to enroll or to cancel your enrollment will* ***not*** *affect your future eligibility to continue FEHB enrollment after retirement.*

Annuitants Who Cancel Their Enrollment

You cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. See the Table on page 6 for events that allow eligible annuitants to reenroll.

Former Spouses (Spouse Equity) Who Cancel Their Enrollment

If you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you stop the enrollment because you acquire other FEHB coverage, your right to FEHB coverage under the spouse equity continues. You may reenroll as a former spouse when the other FEHB coverage ends.

If you cancel a family enrollment, the covered children may be eligible for continued coverage if the children are receiving a survivor annuity based on the service of the other parent, and the other parent had family coverage at the time of death. In this circumstance, you should contact the other parent's retirement system promptly to have the children enrolled as survivor annuitants. The children must enroll for FEHB coverage as survivor annuitants within 31 days after your cancellation.

Temporary Continuation of Coverage Enrollees Who Cancel Their Enrollment

If you cancel your TCC enrollment, you cannot reenroll. Your family members who lose coverage because of your cancellation cannot enroll for TCC in their own right nor can they convert to a nongroup policy. However, family members who are Federal employees or annuitants may enroll in the FEHB Program when you cancel your coverage if they are eligible for FEHB coverage in their own right.

Note 1: *If you become covered by a regular enrollment in the FEHB Program, either in your own right or under the enrollment of someone else, your TCC enrollment is suspended. You will need to send documentation of the new enrollment to the employing office maintaining your TCC enrollment so that they can stop the TCC Enrollment. If your new FEHB coverage stops before the TCC enrollment would have expired, the TCC enrollment can be reinstated for the remainder of the original eligibility period (18 months for separated employees).*

Note 2: *Former spouses (spouse equity) and temporary continuation of coverage enrollees who fail to pay their premiums within specified time frames are considered to have voluntarily cancelled their enrollment.*

Privacy Act Statement

The information you provide on this form is needed to document in your records file maintained by your employing office your enrollment in the Federal Employees Health Benefits Program under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs. In addition, to the extent this information indicates possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

We also request that you provide your Social Security Number so that it may be used as your individual identifier in the Federal Employees Health Benefits Program. Executive Order 9397, dated November 22, 1943, allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

Agencies other than the Office of Personnel Management may have further routine uses for disclosure of information from the records systems in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement

We think this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Management and Budget, Paperwork Reduction Project (3206-0160), Washington, D.C. 20503.

TABLE OF PERMISSIBLE CHANGES IN ENROLLMENT

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

No.	Events That Permit Enrollment Change Event	Change Permitted From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
1	**Open Season.**	Yes*+	Yes	Yes	**As announced by the Office of Personnel Management.**
2	**Change in marital status. (Marriage, divorce, annulment, death of spouse.)**	Yes*+	Yes (Except former spouses)	Yes (Except former spouses)	**From 31 days before to 60 days after change in martial status.**
3	**Other change in family status. (For example, birth of a child, legal separation, discharge from military service of a spouse or of a child under age 22).**	No	Yes	No	**Within 60 days after change in family status.**
4	**Enrollee or family member moves from an area served by a prepaid plan (CMP/HMO) in which enrolled at time of move.**	Does not apply	Yes	Yes	**At any time after presenting written notice to the employing office of the move.**
5	**Termination of enrollment by employee organization plan because of termination of membership in organization.**	Does not apply	No	Yes	**Within 31 days after termination of enrollment in plan.**
6	**Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage other than by cancellation or change to Self Only of the covering enrollment; or employee, covered under another federally sponsored health benefits program, loses such coverage for any reason.**	Yes*	Does not apply	Does not apply	**Within 31 days after termination (except, for employees, withihn 60 days after the death of the enrollee). Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.**
7	**Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage because of change of the covering enrollment from Family to Self Only.**	Yes, for Self Only*	Does not apply	Does not apply	**Within 31 days after change of covering enrollment has been filed. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the change to Self Only was filed, there will be a break in coverage.**
8	**Employee transfers to overseas post of duty from the United States, or reverse.**	Yes*	Yes	Yes	**Within 31 days before or after move.**
9	**Employee returns to active civilian duty or annuitant separates from military service which was not limited to 30 days or less.**	Yes*+	Yes	Yes	**Within 31 days after return to active civilian duty or separation from military service.**
10	**Your plan stops participating in the FEHB Program.**	Does not apply	Yes	Yes	**As set by the Office of Personnel Management.**
11	**Self Only enrollment under this Program of employee's or annuitant's spouse terminates as a result of change in spouse's Federal employment status of 365 days' nonpay status.**	No	Yes	No	**Within 31 days after termination of spouse's enrollment. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.**
12	**Employee who is not enrolled loses coverage under parent's non-Federal health plan.**	Yes*	Does not apply	Does not apply	**Within 31 days after loss of coverage, except within 60 days after the death of the parent.**
13	**Enrolled employee retires from overseas post of duty and is eligible to continue enrollment as annuitant.**	Does not apply	Yes	Yes	**Within 60 days after retirement.**
14	**Enrollee becomes eligible for Medicare.**	Does not apply	No	Yes	**At any time beginning 30 days before becoming eligible for Medicare.**
15	**Enrollee's eligible child (or children) loses coverage under another's FEHB enrollment.**	No	Yes	No	**Within 31 days after child's (children's) loss of coverage. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.**

*** Individuals must be otherwise eligible to enroll.**
+ Employees only.

**** Also selected effective date information.**

No.	Events That Permit Enrollment Change Event	Change Permitted From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
16	**Employee or an eligible family member loses coverage under Medicaid (State program of medical assistance for the needy).**	Yes* *employee loss*	Yes *family member loss*	Does not apply	**Within 31 days after termination of Medicaid or loss of Medicaid coverage by family member.**
17	**Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage due to cancellation of the covering enrollment.**	Yes*	Does not apply	**You must enroll in the same plan and option as that from which coverage is lost, if eligible to enroll in that plan, within 31 days after cancellation of the covering enrollment. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day period. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the cancellation was filed, there will be a break in coverage.**	
18	**Enrolled employee's employment status changes from full-time to part -time career employmetn as defined in the Federal Employees Part-Time Career Employment Act of 1978.**	No	No	Yes	**Within 31 days after the change in employment status.**
19	**Employee or employee's spouse loses coverage under spouse's non-Federal health plan when spouse terminates employment to accompany employee who accepts a position is directed out of commuting area.**	Yes*	Yes	No	**Within 31 days before or 180 days after move.**
20	**Employee's or annuitant's spouse involuntarily loses his or her non-Federal health insurance coverage, or coverage for his or her dependents; or employee's or annuitant's eligible child (or children) loses non-Federal coverage under the other parent's health plan because the other parent involuntarily loses coverage for his or her dependents.**	Yes*+	Yes	No	**Within 31 days before or after spouse's or dependent's loss of coverage; or within 31 days before or after child's (or children's) loss ov coverage.**
21	**Former spouse who is eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 948-615), as amended, the intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).**	Yes*	Does not apply	Does not apply	**Generally, within 60 days after divorce or within 60 days after the date of OPM's notice of eligibility to enroll.**
22	**Temporary employee completes one year of service in accordance with 5 U.S.C. 8906a.**	Yes*	Does not apply	Does not apply	**Within 31 days after becoming eligible.**
23	**Temporary employee, eligible under 5 U.S.C. 8906a, changes to a nontemporary appointment.**	Yes*	Yes	Yes	**Within 31 days after changing to non-temporary appointment.**
24	**Employee separated from service and eligible for temporary continuation of coverage.**	Does not apply	Yes	Yes	**Within 60 days after the later of: separation; or receiving notice of the opportunity to elect temporary continuation of coverage. Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.**
25	**Child of employee, former employee or annuitant stops meeting the requirements for unmarried dependent children.**	Yes*	Does not apply	Does not apply	**Within 60 days after the later of: the qualifying event; of the child's receiving notice of the opportunity to elect temporary continuation of coverage (based on the enrollee's notification to the employing office of the child's eligibility). Coverage is the day after other FEHB coverage ends, including the 31-day effective extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.**

*** Individuals must be otherwise eligible to enroll.**
+ Employees only.
**** Also selected effective date information.**

No.	Events That Permit Enrollment Change Event	Change Permitted From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
26	Former spouse meets the requirement in 5 U.S.C. 8901(10) of having been enrolled in an FEHB plan as a covered family member at some time during the 18 months before the marriage ended, but does not meet one or both of the other two requirements of 5 U.S.C. 8901(10).	Yes*	Does not apply	Does not apply	Within 60 days after the later of: the qualifying event; the date coverage under Subpart H of 5 CFR Part 890 was lost, if the loss occurred within 36 months of the qualifying event; or the former spouse's receiving notice of the opportunity to elect temporary continuation of coverage (based on the enrollee's or former spouse's notification to the employing office of the former spouse's eligibility). Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage; or the date of the qualifying event, if later. If election is made after the end of the 31-day extension of coverage or the date of the qualifying event, the effective date will be retroactive.
27	Former employee, former spouse or child whose temporary continuation of coverage under 5 CFR Part 890 Subpart K terminates due to other FEHB coverage, loses the other FEHB coverage.	Yes*	Does not apply	You must reenroll in the same plan and option as that in which you were enrolled prior to obtaining the other FEHB coverage, if eligible to enroll in that plan, within 31 days after the other coverage ends, but not later than the expiration of the period of eligibility for the temporary continuation of coverage. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day time limit.	

*** Individuals must be otherwise eligible to enroll.**
**** Also selected effective date information.**
+ Employees only.

HEALTH BENEFITS REGISTRATION FORM

FEHB

Federal Employees Health Benefits Program

Form Approved:
OMB No. 3206-0160

* Complete Part A and Parts B, C, D, and E as applicable.

* Type or Print Firmly.
* Sign and date in Part F.

PART A - *Fill in this part.*

1. Name *(Last, first, middle initial)*	2. Social Security number	3. Date of birth *(mo., day, yr.)*
4. Your home mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female	6. Are you now married? ☐ Yes ☐ No
	7. Daytime telephone number	

PART B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of plan	Enrollment code

2a. Names of family members	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security number *(see instructions)*

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? ☐ No ☐ Yes → Complete 3b

3b. Type of insurance Medicare ☐ No ☐ Yes → *Indicate part(s)* ☐ CHAMPUS ☐ Other private *(specify name)*

PART C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name	2. Present Plan enrollment code	3. Number of event that permits change *(See Table of Permissable Changes)*	4. Date of event that permits change *(mo., day, yr.)*

PART D - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART F certifies that I have read and understand the information regarding this election.

PART E - *CANCELLATION*

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code: ☐☐☐

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right.

My signature in PART F certifies that I have read the information in the instructions regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

PART F - *Fill in this part*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(Do not print)*	2. Date

PART G - *To be completed by agency*

1. Name and address of employing office	2. Date received in employing office	3. Effective date of action	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number	
	7. Personnel contact and telephone number		
	8. Signature of authorized agency official	9. Phone number	

Remarks